LOUISIANA DEPARTMENT OF HEALTH
Medicaid

The Louisiana Health Insurance Premium Payment Program
LaHIPP

BHSF Form LaHIPP
Renewal
Rev. 2/2023

THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM RENEWAL APPLICATION

Medicaid Assistance with Paying Insurance Premiums

- Fill out this application to see if you are qualified to continue receiving assistance from the Louisiana Health Insurance Premium Payment (LaHIPP) Program. LaHIPP may continue to help pay some or all of the health insurance premiums to the policyholder if someone in the family is eligible for private health insurance through a job or an individual plan and has Medicaid.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-877-697-6703** Monday–Friday between 8:00 AM–5:00 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
- Complete and mail this application to **Attn: LaHIPP, 100 Crescent Centre Pkwy, Suite 1000, Tucker, GA 300084** or fax it to **1-888-716-9787**. You can also e-mail a copy of this application to **La.HIPP@la.gov**.

What is your preferred language? ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

► *Please **PRINT** clearly in black ink.*

1 — Policyholder Personal Information

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

2 — Policyholder Contact Information

Mailing Address			Home Address *(if different)*		
P.O. box or street address		Apt/Lot #	Street address		Apt/Lot #
City	State	Zip	City	State	Zip
E-mail address			Home parish *(where you live)*		

Cell phone	Home phone	Other phone

3 — Members of Policyholder's Household

*List **ALL** people living in your home. If no one lives with you, leave this section blank and skip to section 4.*

	Person 1	Person 2	Person 3
Name			
Relationship to you			
Social Security number			
Date of birth			
Sex	☐ Male ☐ Female	☐ Male ☐ Female	☐ Male ☐ Female
Is this person enrolled in a private health insurance plan?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, is this health plan court ordered?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is this person pregnant?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If **YES**, what is the name of the birthing center? *(if applicable)*			

4 — Health Insurance *(other than Medicaid)*

Name of policyholder	Policyholder phone number	
Mailing address of policyholder *(if they do not live in your home)*		
Insurance company name		
Insurance company address		
Insurance company phone	Policy number	Group number
Is this an employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ ESI ☐ IHI		
Policy premium *(if known)* $	How often is the premium paid/deducted? ☐ Weekly ☐ Biweekly ☐ Semi-Monthly ☐ Monthly ☐ Quarterly ☐ Other:_____	

Please provide a front and back copy of the health insurance card for this policy for verification

5 — Register for Premium Reimbursement

*To receive LaHIPP premuim reimbursements download and complete the **W-9 Form** from the website below.*
http://ldh.la.gov/lahipp

Do you or anyone in your household have a bank account that can be used for electronic deposits? ☐ Yes ☐ No

*If you wish to receive LaHIPP premium reimbursements through electronic funds transfers (EFTs) instead of paper checks, visit the website below and download the **EFT Enrollment Form** from that page. Have your bank or financial institution assist you with completing this form.*
http://ldh.la.gov/lahipp

READ AND SIGN THIS APPLICATION

- I understand that I am signing this application under penalty of perjury, which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false or untrue information. I have permission from all of the people listed on the application to both submit their information to the Louisiana Department of Health (LDH) and receive any information about their eligibility and health coverage.
- I understand that LDH is authorized to gather the information requested in this application and any supporting documentation, including social security numbers, under the Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), and the Social Security Act.
- I understand that providing the requested information (including social security numbers) is voluntary. However, failing to provide it may delay or prevent me from getting health coverage through Medicaid or any other insurance affordability program.
- I understand that LDH will check the information I give them to make sure it is correct. I give LDH permission to contact any outside source(s) necessary to check this information, process my application, determine eligibility, and otherwise operate the Medicaid program. These outside sources may include:
  - Federal agencies (such as the Internal Revenue Service, Social Security Administration, and Department of Homeland Security), other state agencies, and/or local government agencies.
  - Banks, financial institutions, and consumer reporting agencies.
  - Employers identified on applications for eligibility determinations.
  - Doctors or other medical providers.
  - Applicants/enrollees, and authorized representatives of applicants/enrollees.
  - LDH contractors engaged to perform a function for the Medicaid program.
  - Anyone else as required or allowed by law.
- I give these outside sources permission to give LDH any information about me, or any person necessary for this application, that it may request. I understand that this permission will end when this application is denied, when my Medicaid eligibility ends, or when I submit a written statement to LDH canceling this permission, whichever comes first. A cancellation may prevent me from being found to be eligible for Medicaid.
- I understand the social security numbers will only be used to get information from these outside sources to verify income, make eligibility determinations, or for other purposes directly connected to the administration of the Medicaid program.
- I know that I must tell Medicaid if anything changes (and is different than) what I wrote on this application. I can visit www.ldh.la.gov/lahipp or call 1-877-697-6703 to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file, calling the US DHHS Regional Office for Civil Rights at 1-800-368-1019, or writing to the LDH at PO Box 4818, Baton Rouge, Louisiana 70821.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed), and if they are that I must report it.
- I agree that by accepting Medicaid, the State of Louisiana or its assignee will be named as the remainder beneficiary of all annuities purchased on or after Feb. 8, 2006 for the total amount of medical assistance paid on my behalf, unless I have a spouse, minor child, or a child with a disability. In these cases, the State of Louisiana must be named as beneficiary after these individuals. I agree to tell Medicaid about any annuity me and my spouse own or co-own regardless if the annuity is irrevocable (cannot be changed) or Medicaid counts it. I understand that I must tell Medicaid about changes made to any annuity, which may affect when payments begin, the amount paid, frequency of payments, and additions to the principal.
- I agree to keep private health insurance coverage for as long as I get premium payments assistance. If I lose my private health insurance, I will notify LaHIPP at 1-877-697-6703.
- I agree that LaHIPP can use the Louisiana Division of Administration's (DOA) LaGov electronic system to make payments to me for my health insurance premiums and that LaHIPP can give DOA and my bank any information that they need in order to make those payments.
- If I think the Health Insurance Marketplace or Louisiana Medicaid has made a mistake, I can appeal its decision. To appeal means to tell someone at the Health Insurance Marketplace or Medicaid that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting Medicaid at 1-888-342-6207. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

Read and sign below

By signing this application I am giving my permission to the State of Louisiana and its agents to verify the information given on this application. Under penalty of perjury, I certify that all information is true and correct to the best of my knowledge. I have read or someone has read to me the " Read and Sign this Application" section of the application.

Sign here:	Date:

THIS PAGE INTENTIONALLY LEFT BLANK.

LOUISIANA DEPARTMENT OF HEALTH
Medicaid

The Louisiana Health Insurance Premium Payment Program
LaHIPP

THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Health Insurance Information Form

- This form **MUST** be completed by the entity providing health insurance to the LaHIPP applicant, in order to make a final determination of eligibility for health insurance premium reimbursement. Although some information may not relate to the applicant or they may not currently have health insurance, this information is still needed.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-877-697-6703** Monday–Friday between 8:00 AM–5:00 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
- Complete and mail this form to **Attn: LaHIPP, 100 Crescent Centre Pkwy, Suite 1000, Tucker, GA 300084** or fax it to **1-888-716-9787**. You can also e-mail a copy of this form to **La.HIPP@la.gov**.

► *Please **PRINT** clearly in black ink.*

1 — Employer's Information	
Employer name	Employer phone number
Employer address	Employer Federal Tax ID *(mandatory)*

2 — Insurance Carrier Information	
Insurance carrier name	Insurance carrier phone number
Insurance carrier address	Insurance carrier fax number *(if applicable)*
Are multiple plans offered by this insurance carrier? ☐ Yes ☐ No *(Please submit a summary of benefits for all plans with this form)*	
Is there an Open/Annual Enrollment Period? ☐ Yes ☐ No	If **NO**, when would changes to insurance go into effect?
If **YES**, what are the dates for this period? Begin date: End date:	When would changes to insurance go into effect for this period?

3 — Insurance Coverage Information

What coverage is provided by the insurance carrier? *(Check all that apply)*

☐ Major Medical ☐ Health Savings Account ☐ Health Reimbursement Account

☐ High Deductible — Amount: _____ ☐ Other: _____

Tell us your policyholder's share of monthly premiums. If any standard tiers are not applicable, please indicate with N/A)

Standard Tiers	Monthly Premium Share *(without wellness credit)*	Plan Deductible Amount
Policyholder Only	$	$
Policyholder and Children	$	$
Policyholder and Spouse	$	$
Family	$	$

How frequent are premiums paid?

☐ Weekly (**48** times a year) ☐ Weekly (**52** times a year) ☐ Biweekly (**24** times a year) ☐ Biweekly (**26** times a year)

☐ Monthly ☐ Semi-Monthly ☐ Annually ☐ Other: _____

4 — Applicant Information (Private Insurance)

Is the LaHIPP applicant actively receiving coverage from an employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the policyholder.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Insurance policy number	Insurance group number

Is this an employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ ESI ☐ IHI

Is the first month's premium due before coverage becomes effective? ☐ Yes ☐ No

Can changes be made to this coverage by the policyholder at times other than open/annual enrollment? ☐ Yes ☐ No

Provide the following information for all dependants of the policyholder who are enrolled or have been enrolled in their health insurance plan. Include information for the policyholder.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

5 — Applicant Information (COBRA)

Is the LaHIPP applicant actively receiving COBRA coverage? ☐ Yes ☐ No *(if **NO**, skip to section 6)*

Provide the following information for the COBRA policyholder.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

When did COBRA coverage begin?	What was the name of their COBRA contact?

COBRA phone number	COBRA fax number *(if applicable)*

Provide the following information for all dependants of the COBRA policyholder who are enrolled or have been enrolled in a COBRA health insurance plan.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

6 — Human Resources Representative Information and Signature

Name of representative completing form

Representative mailing address

Representative phone number	Representative fax number *(if applicable)*	Representative e-mail address

Sign here:	Date:

Thank you for your time in assisting Medicaid and LaHIPP!

The Louisiana Health Insurance Premium Payment Program

LaHIPP